TO: INSURED EMPLOYEES ON APPROVED LEAVE OF ABSENCE DUE TO PERSONAL ILLNESS/INJURY (INCLUDING CLAIMS FOR INDUSTRIAL ACCIDENT)

FROM: The Group Insurance Commission

RE: Application to Continue Part Cost Premiums

This Application for Reduction of Monthly Premium (Form 11) is required for all insured employees who are on approved leave of absence due to:

- Maternity
- Personal illness
- Workers Compensation/Industrial Accident

Approval of this application by the GIC will entitle you to continue part cost premiums for your group insurance coverage; this is the premium that is normally deducted from your salary.

While you are on this approved leave of absence your monthly group insurance premiums are usually not payroll deducted and you are required to remit payment directly to the GIC.

If the leave of absence is NOT approved by the Agency Head, you will be billed at the full cost premium.

THE FOLLOWING FOUR ITEMS MUST BE RETURNED TOGETHER. INCOMPLETE APPLICATIONS WILL NOT BE PROCESSED.

1. Page one: Completed by you, the employee
2. Page two: Completed by you and the Agency Head
3. Page three: Completed by your physician
4. Letter approving Leave of Absence: Completed by your Agency Head

SECTION ONE (To Be Completed by Employee)

Name		GIC ID NO. (usually Social Security no.) — —	
Street Address	City	State	Zip
Date of Birth		Home Telephone No. ( ) —	
Place of Employment		Occupation	
Last Day of Work		Expected Date of Return to Work	
Nature of Illness or Injury			

I hereby certify under the pains and penalties of perjury that I am not entitled to receive any salary, wages or other compensation from my employer and my absence is due to my own illness, or injury, and NOT the illness or injury of another person. I understand that this application shall not create an insurable interest or otherwise reinstate coverage which has been terminated. I also understand that any leave which is granted to me will be subject to periodic review by the Group Insurance Commission.

Signature of Employee _____ Date_____

SECTION TWO (To Be Completed by Agency Head/Employee)

AGENCY MUST ENCLOSE A COPY OF LETTER GRANTING LEAVE OF ABSENCE TO EMPLOYEE

1. Is this employee on Approved Leave of Absence due to Illness or Injury? Yes ☐ No ☐

If yes, reason: Illness ☐ Injury ☐ Maternity ☐ Worker's Compensation/Industrial Accident ☐

Duration of Leave From: _____ To: _____
PROVIDE SPECIFIC DATES ONLY Month/Day/Year Month/Day/Year

2. Balance of: Vac. Days ☐ Pers. Days ☐ Sick Days ☐ Comp. Days ☐

3. Last Day Employee on Payroll _____

4. Does the employee hold a Civil Service position? Yes ☐ No ☐ Does Not Apply to Agency ☐

If yes or does not apply to agency, continue to number 5.

If no, please complete the following:

It is hereby agreed that _____ will be reappointed to his/her current
(print name of employee)

position of _____, if it is available, or to a similar position to which he/she is entitled upon return from his/her medical leave of absence.

_____ _____
Signature of Agency Head/Department Head Date

I hereby agree to return to work in my current position, or a similar position, or to a position to which I am otherwise entitled at the conclusion of such leave of absence.

_____ _____
Signature of Employee Date

5. Briefly describe the Employee's job duties:

6. Please complete the following information:

Name of Agency Head _____ Title _____

Telephone Number ( ) _____

_____ _____
Signature of Agency Head/Department Head Date

SECTION THREE (To Be Completed by Physician)

(Please attach additional sheets if necessary)

1. Name of Patient:
2. Patient's Diagnosis and date of onset of illness:
3. How long have you been treating this patient for this diagnosis?
4. Describe your treatment plan and prognosis for this patient in as much detail as possible:
5. Can the patient return to work at this time? Yes ☐ No ☐

   If no, when do you think the patient will be able to return to work?
6. Please indicate any alterations in the work requirements that would enable the patient to return to work earlier. (Please explain in detail):

I hereby certify that I have examined the above named patient and certify under the pains and penalties of perjury that the information listed above is true, based upon my knowledge and belief.

Signature of Physician _____ Date _____

Please print the following information:

Name of Physician

Street Address City State Zip

Telephone Number ( )

Specialty

Registration Number

SECTION FOUR (FOR GIC USE ONLY)

VALIDATION INFORMATION

Employee's Coverage _____ Effective Date _____

Agency _____ Division _____

APPROVAL/DISAPPROVAL INFORMATION

☐ Approval From _____ To _____

☐ Disapproval reason _____

Reviewed by _____ _____
GIC Supervisor Date

COMMENTS